

**County of Milwaukee**  
Interoffice Communication

DATE: January 13, 2014

TO: Sup. Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors  
Sup. Jason Haas, Chair, Intergovernmental Relations Committee

FROM: Stephanie Sue Stein, Director, Department on Aging

RE: Requesting authorization to support the Wisconsin Department of Health Services (DHS) recommendation that Family Care be expanded to include the remaining 15 counties in Wisconsin that currently do not have the benefit, and to authorize and direct the Department of Government Affairs to communicate Milwaukee County's position to State policymakers and DHS administrators

I respectfully request that the attached resolution be scheduled for consideration by the Intergovernmental Relations Committee at its next meeting.

The attached resolution requests authorization to support the Wisconsin Department of Health Services (DHS) recommendation that Family Care be expanded to include the remaining 15 counties in Wisconsin that currently do not have the benefit, and to authorize and direct the Department of Government Affairs to communicate Milwaukee County's position to State policymakers and DHS administrators.

In addition to the fundamental fairness of having all eligible Wisconsin residents served under the same program, providing the Family Care entitlement statewide to persons in need of long term care will eliminate waitlists. In addition, it is estimated by DHS that Wisconsin will save \$34.7 million over the next ten years by expanding Family Care to include the remaining 15 counties not currently in the program.

If you have any questions, please call me at 2-6876.




---

Stephanie Sue Stein, Director  
Milwaukee County Department on Aging

cc: County Executive Chris Abele  
Raisa Koltun  
Eric Peterson  
Matthew Fortman  
Stephen Cady  
Janelle Jensen  
Jonette Arms  
Thomas Condella  
Mary Proctor Brown  
Chester Kuzminski  
Jonathan Janowski  
Gary Portenier  
Pat Rogers

Attachments

## **A Resolution**

Supporting state efforts to expand the Family Care program to all remaining 15 counties in Wisconsin that currently do not have the benefit.

WHEREAS, Many people in Milwaukee County and throughout Wisconsin need help with activities of daily living and caring for their health due to a physical or developmental disability or because of the increasing challenges that come with aging; and

WHEREAS, In October 1999, the State of Wisconsin enacted legislation to redesign the state's long-term care system, and a new benefit called Family Care was developed with the help of older adults, service providers, advocates, and state policy specialists; and

WHEREAS, As a comprehensive long-term care service system, Family Care strives to foster people's independence and quality of life while recognizing the need for interdependence and support; and

WHEREAS, In 2000 there were approximately 2,500 seniors in Milwaukee County on waiting lists in need of long-term care, and the State of Wisconsin launched the Family Care program as a pilot program in five Wisconsin counties; and

WHEREAS, Milwaukee County was one of the five pilot counties, and the Milwaukee County Department on Aging was selected to operate both the Aging Resource Center and Managed Care Organization components of the Family Care program in Milwaukee County; and

WHEREAS, The Milwaukee County Department on Aging successfully operated the Managed Care Organization (MCO) until 2010, when Wisconsin statutes and administrative regulations prohibited the same local agency from operating both the Aging Resource Center and MCO; and

WHEREAS, The Milwaukee County Board of Supervisors approved separation of the MCO from the Milwaukee County Department on Aging and, effective July 1, 2010, created the Milwaukee County Department of Family Care to operate the MCO; and

WHEREAS, The Milwaukee County Department of Family Care is a leader in providing the Family Care program in Milwaukee County, currently serving over 8,100 members; and

WHEREAS, Over the past 13 years, Milwaukee County has successfully served more than 21,722 Family Care members; and

WHEREAS, The Medicaid waiver agreement between the Centers for Medicare and Medicaid Services and the State of Wisconsin under which the Family Care program operates indicates

that the program would ultimately be available statewide, although the agreement does not specify a date by which this must happen; and

WHEREAS, A December 2013 report by the Wisconsin Department of Health Services shows that the expansion of Family Care, and the entitlement of support in homes and community-integrated settings, allows Wisconsin residents to receive cost-effective long-term supports, and that expanding the Family Care Program to the remaining 15 counties in Wisconsin that currently do not have the program would save \$34.7 million over the next ten years and eliminate waiting lists for 1,600 people; now, therefore,

BE IT RESOLVED, that Milwaukee County commends the Wisconsin Department of Health Services for its December 2013 report on Family Care, and fully supports the Department's recommendation that Family Care be expanded to the remaining 15 counties in Wisconsin that currently do not have the program, and

BE IT FURTHER RESOLVED, that Milwaukee County asks the State Legislature's Joint Finance Committee and entire State Legislature to approve Family Care expansion to the remaining 15 counties in Wisconsin that currently do not have the program, and

BE IT FURTHER RESOLVED, that the Department of Government Affairs is authorized and directed to communicate Milwaukee County's position to State policymakers and Department of Health Services administrators.

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** January 13, 2014

Original Fiscal Note ☒

Substitute Fiscal Note ☐

**SUBJECT:** Resolution supporting Family Care expansion to the remaining 15 counties (those not yet in the program).

### FISCAL EFFECT:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact                                     | <input type="checkbox"/> Increase Capital Expenditures |
| <input checked="" type="checkbox"/> Existing Staff Time Required                                       | <input type="checkbox"/> Decrease Capital Expenditures |
| <input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues     |
| <input type="checkbox"/> Absorbed Within Agency's Budget   | <input type="checkbox"/> Decrease Capital Revenues     |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget   |  |
| <input type="checkbox"/> Decrease Operating Expenditures   | <input type="checkbox"/> Use of contingent funds       |
| <input type="checkbox"/> Increase Operating Revenues   |  |
| <input type="checkbox"/> Decrease Operating Revenues   |  |

*Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.*

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	
	Revenue	0	
	Net Cost	0	
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

## DESCRIPTION OF FISCAL EFFECT

**In the space below, you must provide the following information. Attach additional pages if necessary.**

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.<sup>1</sup> If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

- A. A resolution in support of state efforts to expand the Family Care program to the remaining fifteen counties in Wisconsin that currently do not have the benefit.
- B. N/A
- C. N/A
- D. No assumptions made.

Fiscal impact would include the allocation of staff time required to prepare the accompanying report and resolution.

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Department/Prepared By: Department on Aging / Gary W. Portenier



Authorized Signature \_\_\_\_\_

Did DAS-Fiscal Staff Review?    ☐    Yes    ☒    No

Did CBDP Review?<sup>2</sup>    ☐    Yes    ☐    No    ☒    Not Required

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If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

<sup>2</sup> Community Business Development Partners’ review is required on all professional service and public work construction contracts.



OFFICE OF THE COUNTY EXECUTIVE  
*Milwaukee County*  
CHRIS ABELE • COUNTY EXECUTIVE

TO: Marina Dimitrijevic, Chair, Milwaukee County Board Of Supervisors

FROM: Chris Abele, Milwaukee County Executive

DATE: January 17, 2014

RE: **Resolution in support of proposals to raise the Minimum Wage**

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Pursuant to statutory authority granted to me, I am submitting for the Board's consideration and action a resolution in support of federal and state legislation to raise and index the minimum wage. I appreciate the Board's consideration of this matter and urge action in the coming cycle.

1 By the County Executive, Chris Abele  
2  
3

4 **A RESOLUTION**

5 In support of federal and state legislation to raise and index the minimum wage.  
6

7 WHEREAS, the federal minimum wage is currently set at \$7.25 per hour and is not  
8 indexed for inflation and was last increased by congressional action in 2009 and the state  
9 minimum wage matches the current federal level at \$7.25 per hour; and  
10

11 WHEREAS, a broadly applied minimum wage benefits those at the bottom end of  
12 the wage scale without hindering localities' competitiveness relative to others; and  
13

14 WHEREAS, numerous studies show that when attempting to address income  
15 inequality through raising the minimum wage it is preferable to utilize as broad an action  
16 as possible rather than localized initiatives which can reduce economic competitiveness;  
17 and  
18

19 WHEREAS, Senator Tom Harkin and Senate Majority Leader Harry Reid have  
20 introduced S 1737, the "*Minimum Wage Fairness Act*" which will raise the minimum wage  
21 incrementally over three years to \$10.10 in 2016 and thereupon provide for annual  
22 indexing of the wage rate by the Labor department based on increases in the Consumer  
23 Price Index; and  
24

25 WHEREAS, Representative George Miller and 154 cosponsors, including three  
26 Wisconsin Representatives, Gwen Moore, Mark Pocan, and Ron Kind, have introduced the  
27 companion bill, the "*Fair Minimum Wage Act of 2013*" (H.R. 1010) in the United State  
28 House of Representatives; and  
29

30 WHEREAS, in November of 2013, the President of the United States, Barack  
31 Obama, announced his support for the legislation and urged Congress to act on this  
32 legislation; and  
33

34 WHEREAS, Representatives Cory Mason and Eric Genrich along with Senators Bob  
35 Wirth and Nikiya Harris have introduced draft legislation, LRB 3599, which will raise the  
36 state minimum wage to correspond to the federal proposal of \$10.10 per hour and provide  
37 for future indexing of the wage; and  
38

39 WHEREAS, the County Executive and other elected officials have been supportive of  
40 past efforts to raise the minimum wage and support fully this federal and state legislation;  
41 and  
42

43 WHEREAS, support for this legislation is consistent with the mission of Milwaukee  
44 County to "enhance self-sufficiency...and economic opportunity and quality of life for all its  
45 people"; now, therefore

1  
2       BE IT RESOLVED, that Milwaukee County adopts a position in support of federal  
3 legislation, S 1737 and H.R. 1010, and state legislation such as LRB 3599 to raise the  
4 minimum wage to \$10.10 and encourage its swift passage; and  
5

6       BE IT FURTHER RESOLVED, that upon adoption, the Milwaukee County Clerk is  
7 authorized and directed to send copies of this resolution to members from Wisconsin of the  
8 United States Congress; and  
9

10       BE IT FURTHER RESOLVED, that Department of Government Affairs is authorized  
11 to communicate this position to elected officials and advocate for this legislation's  
12 enactment into law.

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** 1/24/2014

Original Fiscal Note ☒

Substitute Fiscal Note ☐

**SUBJECT:** Supporting federal and state legislation to raise and index the minimum wage; and authorizing the Department of Government Affairs to advocate for related legislation.

### FISCAL EFFECT:

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| <input checked="" type="checkbox"/> No Direct County Fiscal Impact                                     | <input type="checkbox"/> Increase Capital Expenditures |
| <input checked="" type="checkbox"/> Existing Staff Time Required                                       | <input type="checkbox"/> Decrease Capital Expenditures |
| <input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues     |
| <input type="checkbox"/> Absorbed Within Agency's Budget   | <input type="checkbox"/> Decrease Capital Revenues     |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget   |  |
| <input type="checkbox"/> Decrease Operating Expenditures   | <input type="checkbox"/> Use of contingent funds       |
| <input type="checkbox"/> Increase Operating Revenues   |  |
| <input type="checkbox"/> Decrease Operating Revenues   |  |

*Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.*

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	\$0	\$0
	Revenue	\$0	\$0
	Net Cost	\$0	\$0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

## DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.<sup>1</sup> If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

- A. This resolution would express support for the concept of raising and indexing the minimum wage at the State and Federal levels, and would authorize the Department of Government Affairs to express the County's position on this issue and to advocate for related legislation.

This resolution has no fiscal impact because it would express the County's position on an issue and authorize the Department of Government Affairs to engage in activities for which it is fully funded in its operating budget.

No additional assumptions have been made.

Department/Prepared By Josh Fudge, Director, Office of Performance, Strategy and Budget

Authorized Signature



Did DAS-Fiscal Staff Review?

☒

Yes

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No

Did CDBP Review?<sup>2</sup>

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Yes

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No

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Not Required

<sup>1</sup> If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

**MILWAUKEE COUNTY**  
**Interoffice Memo**

**DATE:** January 17, 2014

**TO:** Supervisor Marina Dimitrijevic, Chairwoman, Board of Supervisors  
Supervisor Jason Haas, Chair, Intergovernmental Relations Committee

**FROM:** Jim Sullivan, Director of Child Support Services

**RE:** A Resolution Opposing Assembly Bill 540

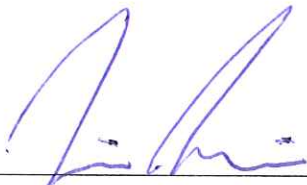
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Assembly Bill 540 proposes to significantly alter how child support orders are determined and how they are modified.

This bill could have a significant impact on the livelihood of children and families in Milwaukee County, which is why the department would support the County taking a position in opposition to Assembly Bill 540.

Please let me know if you have any questions.

Respectfully submitted,



---

Jim Sullivan, Director  
Department of Child Support Services

cc: County Executive Chris Abele  
Amber Moreen  
Eric Peterson  
Kelly Bablitch  
Jamie Kuhn  
Stephen Cady  
Jodi Mapp

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**A RESOLUTION**  
Opposing State Assembly Bill 540

WHEREAS, 2013 Wisconsin State Assembly Bill 540 proposes to significantly alter how child support orders are to be determined initially and how they may be modified; and

WHEREAS, in setting initial child support orders, such alterations include: the elimination of any consideration of a parent's assets; an income cap of \$150,000 regardless of a parent's actual income; and the restriction of courts' discretion to deviate from the state child support standards when such standards are unfair to the child or either parent by only allowing downward deviations, but not upward deviations; and

WHEREAS, in modifying child support orders, such alterations curtail courts' discretion in determining appropriate outcomes for individual cases by requiring the modification of existing child support orders if the court finds a substantial change in circumstances, whether or not such change actually warrants modification; and

WHEREAS, these changes would negatively impact the ability of the Milwaukee County Courts and Department of Child Support Services to establish and enforce appropriate support orders for the children and families of Milwaukee County; and

BE IT RESOLVED, Milwaukee County hereby expresses its opposition to the passage of State Assembly Bill 540; and

BE IT FURTHER RESOLVED, Government Affairs staff is authorized and directed to communicate Milwaukee County's opposition to AB 540 to State policymakers and other related officials as appropriate.

## MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: January 10, 2014

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: A resolution opposing AB 540

### FISCAL EFFECT:

- ☒ No Direct County Fiscal Impact
- ☒ Existing Staff Time Required
- ☐ Increase Operating Expenditures  
(If checked, check one of two boxes below)
- ☐ Absorbed Within Agency's Budget
- ☐ Not Absorbed Within Agency's Budget
- ☐ Decrease Operating Expenditures
- ☐ Increase Operating Revenues
- ☐ Decrease Operating Revenues
- ☐ Increase Capital Expenditures
- ☐ Decrease Capital Expenditures
- ☐ Increase Capital Revenues
- ☐ Decrease Capital Revenues
- ☐ Use of contingent funds

*Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.*

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

## DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.<sup>1</sup> If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

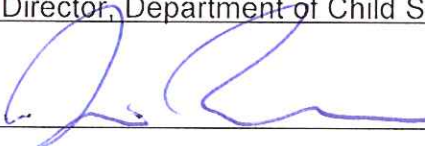
Approval of this resolution will indicate Milwaukee County's opposition to 2013 Assembly Bill 540 ("AB540").

This State legislation proposes to significantly alter how child support orders are to be determined initially and how they may be modified. According to the Director of Child Support Services, these changes would negatively impact the ability of the Milwaukee County Courts and Department of Child Support Services to establish and enforce appropriate support orders for the children and families of Milwaukee County.

This resolution will not require an expenditure of funds, but will require staff time to communicate its contents to State policymakers and other stakeholders.

Department/Prepared By Jim Sullivan, Director, Department of Child Support Services

Authorized Signature



Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CBDP Review?<sup>2</sup> ☐ Yes ☐ No ☒ Not Required

<sup>1</sup> If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

1 By Supervisor Alexander  
2  
3

4 **A RESOLUTION**

5 Urging the State of Wisconsin to create and pass legislation placing a one-year  
6 limit on the timeframe in which insurance companies and third party payers  
7 seeking recoupment of previously paid claims may notify the service provider of  
8 such intent.  
9

10 WHEREAS, more than twenty states have established a time limit for  
11 insurance companies to initiate claims when seeking recoupment on previously  
12 paid claims for behavioral and health care services, as evidenced in the refund  
13 recoupment law summary chart attached hereto; and  
14

15 WHEREAS, it is reasonable and prudent that the State of Wisconsin draft  
16 and adopt similar legislation in order to alleviate the draining of valuable  
17 resources from critical service areas which creates revenue shortfalls; and  
18

19 WHEREAS, the Milwaukee County Behavioral Health Division (BHD)  
20 budget is presented in a programmatic format based on service areas that  
21 consist of the following programs;  
22

- 23 ☐ Management/Support Services
- 24 ☐ Inpatient Services
- 25 ☐ Adult Community Services
- 26 ☐ Child and Adolescent Community Services
- 27 ☐ Adult Crisis Services
- 28 ☐ AODA Services  
29

30 and under this format, program costs consist of both direct expenditures and  
31 allocated costs that are attributable to the operation of each program; and  
32

33 WHEREAS, revenues for each program consist of charges directly  
34 associated with the provision of services to patients and other operating  
35 revenues that are not directly related to patient services, and insurance  
36 companies cover some of the costs for services provided to patients, and in turn,  
37 reimburse BHD for services provided; and  
38

39 WHEREAS, within programmatic areas, insurance companies submit  
40 insurance recoupment claims to BHD many years after the initial claim is fulfilled;  
41 and  
42

43 WHEREAS, Wisconsin State Regulation DHS 1 establishes the  
44 requirement that county social service agencies bill their cost for the services  
45 they provide, directing that:  
46

47 DHS 1.05 (6) (a) All billing and collection efforts shall strive toward  
48 what is fair and equitable treatment for both clients who receive  
49 service and taxpayers who bear unmet costs... and, that (c) All  
50 billing and collection activity shall be pursued in a forthright and  
51 timely manner according to these rules:  
52

- 53 1. Where applicable insurance exists, the insurance company shall  
54 be billed directly wherever possible by the unit with collection  
55 responsibility for the facility providing the service. Where a  
56 responsible party is covered by Medicare and private insurance,  
57 Medicare shall be billed for the full coverage it provides and the  
58 private insurance company shall be billed for any remaining  
59 amount. Medicaid, where applicable, is the payer of last resort.  
60 For services exempted by DHS 1.01 (4), third-party  
61 reimbursement shall be pursued where applicable, but direct  
62 billings to the client or other responsible parties shall no occur.  
63 Agencies shall follow the claims processing procedures of third-  
64 party payers to assure payment of claims.  
65
- 66 2. Responsible private parties shall be billed for liability not  
67 covered by insurance, according to the applicable provisions of  
68 DHS 1.03.  
69

70 WHEREAS, payment errors are subject to interpretation by payers and  
71 are generally not eligible for appeal; and  
72

73 WHEREAS, there is an undue strain on taxpayers and staff to go years  
74 back to recalculate patient accounts for possible errors and overpayments; and  
75

76 WHEREAS; the Milwaukee County Behavioral Health Division closes its  
77 books on an annual basis, in consideration of all expenditures and revenues and  
78 these unanticipated recoupment costs create many financial difficulties for BHD  
79 as well as patients, now therefore,  
80

81 BE IT RESOLVED, the Milwaukee County Boards of Supervisors hereby  
82 requests the State of Wisconsin to legislate a one-year limit, from the date of  
83 initial claim payment, on the timeframe in which insurance companies and third  
84 party payers seeking recoupment of previously paid claims may notify the service  
85 provider of such intent and initiate such recoupment claims; and  
86

87 BE IT FURTHER RESOLVED, that upon passage of this resolution, the  
88 Milwaukee County Clerk is authorized and directed to send copies of this  
89 resolution to the Governor of Wisconsin and the Milwaukee County State  
90 Delegation.  
91  
92

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** September 12, 2013

Original Fiscal Note ☒

Substitute Fiscal Note ☐

**SUBJECT:** Urging the State of Wisconsin to create and pass legislation placing a one-year limit on the timeframe in which insurance companies and third party payers seeking recoupment of previously paid claims may notify the service provider of such intent.

### FISCAL EFFECT:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact                                     | <input type="checkbox"/> Increase Capital Expenditures |
| <input checked="" type="checkbox"/> Existing Staff Time Required                                       | <input type="checkbox"/> Decrease Capital Expenditures |
| <input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues     |
| <input type="checkbox"/> Absorbed Within Agency's Budget   | <input type="checkbox"/> Decrease Capital Revenues     |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget   |  |
| <input type="checkbox"/> Decrease Operating Expenditures   | <input type="checkbox"/> Use of contingent funds       |
| <input type="checkbox"/> Increase Operating Revenues   |  |
| <input type="checkbox"/> Decrease Operating Revenues   |  |

*Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.*

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

## DESCRIPTION OF FISCAL EFFECT

**In the space below, you must provide the following information. Attach additional pages if necessary.**

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
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- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Approval of this resolution will urge the State of Wisconsin to create and pass legislation placing a one-year limit on the timeframe in which insurance companies and third party payers seeking recoupment of previously paid claims may notify the service provider of such intent.

Approval of this resolution will not require an expenditure of funds, but will require staff time to communicate its contents to State policymakers.

Department/Prepared By CB/Martin Weddle

Authorized Signature \_\_\_\_\_

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CBDP Review?<sup>2</sup> ☐ Yes ☐ No ☒ Not Required

<sup>1</sup> If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.



DEPARTMENT OF HEALTH & HUMAN SERVICES  
BEHAVIORAL HEALTH DIVISION

*Milwaukee County*

Note Date



May 13, 2011

ForwardHealth  
Managed Care Appeals  
PO Box 6470  
Madison, WI 53716-6470

To Whom It May Concern::

This letter is in reference to an Overpayment Notification from OptumHealth Behavioral Solutions for Milwaukee County Mental Health Complex, Tax ID 396005720 (see attached). The overpayment is in the amount of \$115917.50 representing 9 member episodes from 2006. ← Note Date.

For all 9 episodes, the overpayment reason was "incorrect contract rate applied" and contained the following note:

*NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 715 is reimbursed at a base rate of \$500.00 times a weight of 1.1223 = \$5611.50*

*NOTES: Wisconsin Non Par Medicaid Rates provide that DRG 714 is reimbursed base rate of \$5000.00 times a weight of 2.0075 = \$10037.50.*

During 2006, the United Health Group paid all Milwaukee County charges based on our per diem rate. This is true of the claims in question. This overpayment claim is one of nine long-stay 2006 claims UBH has hand picked as an overpayment based on conversion to a DRG rate. UBH cannot opt to have long-stay episodes paid using the DRG and short stay claims paid using the per diem rate. If UBH wishes to change from a per diem to a DRG rate for 2006 claims, it must be done for all claims in 2006 reflecting a total underpayment of \$91,272.09. The Milwaukee County Behavioral Health Division will agree to pay the overpayment for this claim when it receives a check from UBH for the 2006 claims that were underpaid based on the DRG rate. I have attached a spreadsheet for the 2006 claims.

Your prompt attention to this matter is greatly appreciated.

Sincerely,

*N. Maslanka*

Nicki Maslanka  
Accounts Receivable/Billing Supervisor  
Milwaukee County Behavioral Health Division  
(414) 257-6675  
nicole.maslanka@milwcnty.com

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
ALABAMA	Al 27-1-17	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim after the expiration of one (1) year from the date the claim was initially paid or after the expiration of the same period of time that the health care provider is required to submit claims, whichever date occurs first.	An insurer, health service corporation, or health benefit plan shall not retroactively seek recoupment or refund of a paid claim for any reason that relates to the COB of another carrier responsible for the payment of the claim after expiration of eighteen (18) months from the date claim was paid.	An insurer, health service corporation, and health benefit plan shall not retroactively seek recoupment or refund of a paid claim from provider for any reason, other than fraud or coordination of benefits or for duplicate payments after the expiration of one year from the date that the initial claim was paid.	12 Months
ALASKA	AS 21.54.020	A healthcare insurer can recover an amount, wrongly paid to a provider.	—	—	No Limit
ARKANSAS	Ann. § 23-61-108, §23-63-1806, §25-15-201	A health care insurer cannot seek refund of paid claim after the expiration of eighteen (18) months from the date the claim was initially paid.	A health care insurer has one hundred and twenty (120) days from the date of payment to notify the provider of a verification error and the fact that services rendered will not be covered if the error was made in good faith at the time of the verification.	Except in cases of fraud committed by the health care provider, means fraud that the insurer discovered after the eighteen (18) month period and could not have discovered prior to the end of the eighteen-month period.	18 Months
ARIZONA	§20-3102	A health care insurer shall not adjust or request adjustment of a payment or denial of claim more than one year after the date health care insurer has paid the claim. If a provider and insurer agree through contract about adjustment then even they have same length of time to request adjustment of a claim. Once claim is adjusted an insurer or provider shall owe no interest on the overpayment or underpayment resulting from the adjustment as long as the adjustment or recoupment taken within the period of 30 days of the date of claim adjustment.	—	This Section shall not apply in case of fraud.	12 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
CALIFORNIA	110133.66 (2005 Cal ALS 441; 2005 Cal SB 634; Stats 2005 ch.44)	Reimbursement request for the overpayment of a claim shall not be made, unless a written request for reimbursement is sent to provider within 365 days of the date of payment on the overpaid claims.	—	Time limit of 365 days shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.	12 Months
COLORADO	C.R.S 10-16-704 (2009)	Adjustments to claims by the carrier shall be made within the time period set out in contract between the provider and the carrier. The time period shall be the same for the provider and the carrier and shall not exceed 12 months after the date of the original explanation of benefits. If no contract exists then adjustments to claims shall be made 12 months after the date of the original explanation of benefits.	Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including medicare and medicaid, shall be made within thirty-six (36) months after the date of service.	Adjustments to claims made in cases where a carrier has reported fraud or abuse committed by the provider, shall not be subject to the requirements of this subsection.	12 Months
CONNECTICUT	SB 764	Insurers and HMOs are prohibited from seeking to recover an overpayment for a claim paid under a health insurance policy unless they provides written notice to the person from whom recovery is sought within five (5) years after receiving the initial claim.	—	—	60 Months
DISTRICT OF COLUMBIA	D.C Code § 31-3133	Insurer may only retroactively deny reimbursement to provider for services subject to COB during the 18-month period after the date that the health insurer paid the health care provider; or during the 6-month period after the date that the health insurer paid the health care provider.	A health insurer that retroactively denies reimbursement to a health care provider shall provide a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from COB, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.	This section will not apply if information submitted was fraudulent; or improperly coded or duplicate claim or does not otherwise conform with the contractual obligations. If insurer retroactively denies reimbursement for services as a result of cob the provider shall have 180 days after the date of denial, unless the insurer permits longer time insurer that denies reimbursement to provider shall give provider a written notice specifying the basis for the retroactive denial. This section shall not apply to an adjustment to reimbursement made as an annual contracted reconciliation of a risk-sharing arrangement.	6 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
FLORIDA	FL §627.6131	If an overpayment in result of retroactive review or audit of coverage decisions or payment levels a health insurer must submit the claims details to provider within 30 months after the health insurer's payment of the claim.	A provider must pay, deny, or contest the claim for overpayment within 40 days after the receipt of the claim and must pay or deny within 120 days of the receipt. Failure to the above creates an uncontestable obligation to pay the claim. The health insurer may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health insurer's overpayment claim.	Time limit of 30 months. Except in the case of fraud committed by the health care provider.	30 Months
GEORGIA	O.C.G.A. § 33-20A-62	No carrier may conduct a post payment audit or impose a retroactive denial of payment on any claim that was submitted within 90 days of the last date of service or discharge covered by such claim unless: (1) notice of intent to conduct such an audit is provided; (2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim; (3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of refund due within 18 months of the last date of service or discharge covered by such claim	No insurance carrier may conduct a post-payment audit or impose a retroactive denial of payment on any claim submitted after 90 days unless a written notice is provided, not more than 12 months have elapsed and it should be finalized within 24 months.	Any such audit must be completed within 18 months from the date of final discharge of claim.	18 Months
INDIANA	IC 27-8-5.7-10	Insurance may request the provider to repay the overpayment or adjust a subsequent claim after the expiration of two years from the date claim is paid.	—	This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the claim on which the overpayment or underpayment was made.	24 Months
IOWA	191-15.33 (507B)	Insurance may not audit a claim more than two years after the submission of the claim to insurer & not a claim billed for less than \$25.00.	—	The law applies only if the carrier did not suspect fraud.	24 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
KENTUCKY	304-17A-708	An insurer shall not be required to correct a payment error made to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.	—	Time limitation shall not be applicable in case of fraud.	24 Months
LOUISIANA	LRS 22:250.38	health insurance shall provide the health care provider written notification in accordance with LRS 22:250.38. Health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action.	If a healthcare provider disputes insurance's notification of recoupment and a contract exists, the dispute shall be resolved according to terms of contract. If no contract exists, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq.	—	—
MAINE	24-A - §4303.	The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.	—	The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: 1. The claim was submitted fraudulently 2. Duplicate payment 3. Services identified in the claim were not delivered by the provider 4. Adjustment with another insurer COB 6. The claim payment is the subject of legal action.	12 Months
MARYLAND	M. A. Code section 15-1008	A carrier may only retroactively deny reimbursement paid to healthcare provider during the six month period after the date the carrier paid the claim.	This Section Provides time frame for the period of 18 months in case of services subject to coordination of benefits with another carrier.	The time period is not limited if: 1. Information submitted was fraudulent. 2. Improperly Coded 3. Payment was made for duplicate claim. 4. a claim submitted to MCO & the claim was for services provided to a MD Medical Assistance Program recipient during a time period when Program has permanently retracted the capitation payment for the Program recipient.	6 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
MASSACHUSETTS	HB 976	The time which has elapsed since the date of payment of the challenged claim does not exceed 12 months.	—	The retroactive denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: (1) claim was submitted fraudulently; (2) claim payment was incorrect because the provider or the insured was already paid ; (3) health care services were not delivered by the physician/provider; (4) claim payment is the subject of adjustment with another insurer; or (5) claim payment is the subject of legal action	12 Months
MISSOURI	Sec: 376.384	Prohibit requesting a refund or offset against a claim more than twelve months after a health carrier has paid a claim.	—	Except in cases of fraud or misrepresentation by the health care provider.	12 Months
MONTANA	33-22-150	A health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.	—	If insurance does not limit the time for submission of a claim for payment, then insurance may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.	12 Months
NEW HAMPSHIRE	Insurance Code 420-J;8-b.	No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless: (a) the carrier has provided the reason for the retroactive denial in writing to the health care provider; and (b) the time which has elapsed since the date of payment of the challenged claim does not exceed 18 months.	—	Time limit can be extended beyond the period of 18 months provided claim was submitted fraudulently or claim was incorrect because the provider was already paid for the services claim payment is the subject of adjustment with a different insurer.	18 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
NEW JERSEY	C.17B:30-48 Chapter 352	No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made.	No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request.	Claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits.	18 Months
NEW YORK	§ 3224-b	Prohibit HMOs and other insurers from demanding refunds from a physician more than two years after the claim was initially paid.	Require 30 days notice to providers when the insurer is seeking a refund.	This limitation does not apply if it involve fraud, intentional misconduct, abusive billing or when initiated at the request of a self funded plan or required by a federal or state government program.	24 Months
NORTH CAROLINA	—	Depends upon the contractual terms of a healthcare provider and insurance.	—	—	—
OHIO	Revised Code 3901.38.8 & 3901.388	Third party insurer may recover an overpaid amount not later than two year from the date the claim was paid to the provider. The Provider should be informed about the overpayment practices through notice. Provider shall have a right to file appeal. In case of no response from the provider the carrier is free to initiate recovery practices.	—	Time limitation shall not be applicable in case of fraud.	24 Months
OKLAHOMA	§36-1250.5	Act of insurance company will be considered as unfair claim settlement practices act if insurance request refund from the provider after the period of 24 months from the date claim was paid.	—	This section shall not apply where the claim was submitted fraudulently or provider otherwise agrees to make a refund of claim.	24 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
SOUTH CAROLINA	§ 38-59-250	An insurance may not initiate overpayment recovery process from a provider more than 18 months after the initial payment was received by the provider.	An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least 30 business days prior to engaging in the overpayment recovery efforts.	This time limit does not apply to the initiation of overpayment recovery efforts: (1) based upon a reasonable belief of fraud or other intentional misconduct; (2) required by a self-insured plan; or (3) required by a state or federal government program.	18 Months
TEXAS	§ 3.70-3C	The insurer has no later than the 180 day after provider receives payment to recover an "overpayment" must provide written notice and mention specific reasons for request of recovery of funds.	If carrier as secondary payer pays a portion of a claim that should be paid by the primary carrier, the secondary payer may recover overpayment from the carrier that is primarily responsible for that amount. If the portion of the claim overpaid by the secondary payer was also paid by the primary payer, the secondary payer may recover the amount of overpayment from the physician	—	180 Days
UTAH	§ 31A-26-301.6	The insurer may recover any amount improperly paid to a provider or an insured (a) within 24 months of the amount improperly paid for a coordination of benefits error; (b) within 12 months of the amount improperly paid for any other reason; or (c) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program	—	—	12 Months

## REFUND RECOUPMENT LAWS

State	Statute/Code	Time limit for seeking refund of overpaid Claim	Other factors concerning time limit for seeking refund of overpaid Claim	Exemptions	Period
VERMONT	18 V.S.A. § 9418	A health plan shall not retrospective deny a previously paid claim unless at least 30 days notice of any retrospective denial or overpayment recovery is provided in writing to the provider or the time that has elapsed since the date of payment of the previously paid claim does has exceeded 12 months	—	The retrospective denial of a previously paid claim shall be permitted beyond 12 months if (1) the plan has a reasonable belief that fraud or other intentional misconduct has occurred; (ii) the claim payment was incorrect because the health care provider was already paid; (iii) health care services identified in the claim were not delivered by the provider; (iv) the claim payment is subject of adjustment with another health plan; or (v) the claim is the subject of legal action.	12 Months
VIRGINIA	§ 38.2-3407.15	Carrier can only impose retroactive denial of claim if provided the reason for denial, provider was already paid for the services and time period does not exceed the lesser of 12 months or a number of days mentioned in a contract.	—	Exception of fraud is not provided.	12 Months
WASHINGTON	Chapter 48.43.600	A carrier may not request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made.	A carrier may not for reasons related to coordination of benefits with another carrier (a) Request refund from a health care provider; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim.	This Section shall not apply in case of fraud.	24 Months
WEST VIRGINIA	WVC § 33-45-2	Carrier can only deny a claim where a provider was already paid for the service, claim was not covered under the service and provider not entitled to reimbursement for the period of one year from the date when the claim was paid to the provider.	—	Limitation shall not be applicable in case of misrepresentation or fraud by provider.	12 Months

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